Greenwood House
SKILLED NURSING | ASSISTED LIVING
HOMECARE SERVICES | REHABILITATION
HOSPICE CARE | KOSHER MEALS ON WHEELS

Dear Friend:

Thank you for your interest in Greenwood House where we offer Post-Acute Care, Long-Term Care and Hospice Services. Enclosed please find an application form and a guide explaining our Home's role, responsibilities and relationships.

Only fully processed applications will secure a position on our waiting list or a bed consideration. Please take note that completing this application does not guarantee placement to our Home. The following information must be submitted in its entirety:

a. Completed admission application
b. Copies of all insurance cards (front & back)
c. Completed Medical application by primary physician or Medical records from another medical facility
d. Completed financial statements with supporting documentation

Please send the completed application to our admissions office. We will review the information and contact you to set up an appointment for any further follow up.

Thank you for your interest in our Home.

Sincerely,

Richard Goldstein
Richard Goldstein, LNHA
Administrator

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FACILITY CHARGE LIST

ROOM AND BOARD	$423.00	Semi-Private Room
	$470.00	Private Room

THERAPIES

Physical Therapy Evaluation	$200.00
Physical Therapy Treatment	$50.00 per fifteen (15) minutes
Maintenance Sessions	$50.00 per session
Occupational Therapy Evaluation	$200.00
Occupational Therapy Treatment	$50.00 per fifteen (15) minutes
Speech Therapy Evaluation	$250.00
Speech Therapy Treatment	$75.00 per fifteen (15) minutes
Swallowing Therapy Evaluation	$250.00
Swallowing Therapy Treatment	$75.00 per fifteen (15) minutes

Enteral Feeding & Other Specialty Items will be billed based on usage.

PHARMACY will be billed directly from PHARMCARE

Effective: 01/01/2024

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MEDICAL CERTIFICATE

Completed by Family Physician

Patient Name: _____
(Last) (First) (Middle)
Patient Home Address: _____

Date of Birth: _____ Sex: ☐ Female ☐ Male Preferred Pronouns: _____
Advanced Directive / Living Will: ☐ Yes ☐ No
Name of Primary Hospital: _____
Primary Diagnosis: _____
_____
History & Physical: _____
_____
_____
Most Recent Hospital Stay & Reason:
_____
_____
Physical Condition: ☐ Good ☐ Fair ☐ Poor
Height: _____ Weight: _____lbs. ☐ Continent ☐ Incontinent ☐ Foley
Ambulatory Status: ☐ Independent ☐ w/ Assistive Device: _____ ☐ Bedridden
Mental Status: ☐ Alert: _____ (x1,2,3) ☐ Confused ☐ Depressed
Behaviors: ☐ Verbally Abusive ☐ Physically Combative ☐ None
If patient has behaviors, please explain: _____
_____
_____

Allergies: _____
_____
Psychiatric History: _____
_____
Is the patient free from communicable disease? ☐ Yes ☐ No
If no, please explain: _____
Pneumovax: ☐ No ☐ Yes: Date _____
Flu Vaccine: ☐ No ☐ Yes: Date_____
PPD: ☐ No ☐ Yes: _____
COVID Vaccine: ☐ No ☐ Yes: Type _____ Date _____
Recent Labs (within 3 months) ☐ No ☐ Yes, please provide a copy

****Please provide a copy of the current Medication list. ****

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Comments: _____
_____
_____
_____
_____
_____

Primary Emergency Contact / POA: _____
Phone Number: _____
Relationship: _____

Physician Name: _____
Address: _____
Telephone #: _____ **Fax #: _____**
Email Address: _____

I recommend nursing home placement for this patient: ☐ **Yes** ☐ **No**

_____ _____
Physician Signature **Date of Exam**

NJ Nursing Homes Require a Pre-Admission Screening and Resident Review (PASRR) prior to admission to the Home per Federal Regulation 42 CFR 483.106. This form is required for ALL admissions, both short-term and long-term. It is unrelated to payor status.

The attached PASRR can be completed by a physician, social worker or other healthcare professional that is familiar with the applicant's medical/mental health history and current level of psychosocial functioning.

For questions completing the PASRR, please contact our admissions department. The PASRR must be submitted with the patient's medical application.

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New Resident Application

Name of Person Completing this Application: _____

Relationship to Applicant: _____ Date: _____

1. **Personal Information**

   Name of Applicant in Full: _____

   Maiden Name (if applicable): _____

   Date of Birth: _____ Social Security #: _____

   Marital Status: ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced

   Gender Identity: _____ Pronouns: _____

   Current Address: _____

   Phone Number: _____

   Place of Birth: _____ Religion: _____

2. **Emergency Contact Information / Next of Kin**

   1st Contact

   Name: _____ Relationship: _____

   Address: _____

   Mobile Number: _____ Alternate Number: _____

   ☐POA ☐Healthcare Proxy

   Email Address: _____

   Do you consent to receiving text and email notification regarding your loved one? ☐Yes ☐No

   2nd Contact

   Name: _____ Relationship: _____

   Address: _____

   Mobile Number: _____ Alternate Number: _____

   ☐POA ☐Healthcare Proxy

   Email Address: _____

   Do you consent to receiving text and email notification regarding your loved one? ☐Yes ☐No

   3rd Contact

Name: _____ Relationship: _____

Address: _____

Mobile Number: _____ Alternate Number: _____

☐POA ☐Healthcare Proxy

Email Address: _____

Do you consent to receiving text and email notification regarding your loved one? ☐Yes ☐No

3. **Health Insurance Information**

Medicare ID #: _____

Other Insurance

Policy Name: _____ ID #: _____

Prescription Plan: _____ ID #: _____

LTC Insurance: _____ ID #: _____

Medicaid #: _____

Please make sure to provide copies of all insurance cards (front & back) and LTC Policy Benefit Page

4. **Legal Resources:**

Do you have an Attorney? ☐ Yes ☐No

Name: _____

Phone Number: _____

Address: _____

Note: A Power of Attorney should be obtained prior to admission to the Home in the event you are unable to execute your own affairs. Authority granted must include handling of all financial affairs, legal affairs, decisions for medical treatment, and surgical care. You must submit a copy of your executed Power of Attorney to the Director of Social Services or to the Admissions office. You DO NOT need an attorney to complete a Power of Attorney, you DO need to have the document notarized in order for it to be valid. We can provide you with a standard NJ Power of Attorney Form should you need it. You do not need a Power of Attorney as a condition of Admission but it is highly recommended.

Do you have a Power of Attorney: ☐ Yes ☐No

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Name: _____

Address: _____

Phone Number: _____ Financial POA ☐ Healthcare Proxy ☐

If you have multiple Power of Attorney, please list name's, phone number and addresses below:

_____

_____

_____

5. ADVANCE DIRECTIVE

Do you have an Advance Directive / Living Will? **YES ☐** **NO ☐**

If you have an Advance Directive / Living Will, please submit a copy prior to admission. *You will be provided with information on Advanced Directive upon admission should you not have one.*

6. FUNERAL ARRANGEMENTS

Do you have a Pre-Paid Funeral Trust? **NO ☐** **YES ☐**

****If you have a pre-paid funeral trust, please make sure that it is listed as IRREVOCABLE****

Name of Funeral Home: _____

Address: _____

Phone #: _____

7. FINANCIAL INFORMATION

<u> All financial information disclosed below is CONFIDENTIAL AND SECURE. This information is used to help us determine the Financial Status of the applicant. **</u>**

Does the Applicant own a Home? **NO ☐** **YES ☐**

If **yes**, please provide the address: _____

Is the Applicant the Sole Owner of the Home? **NO ☐** **YES ☐**

If **no**, please provide the name & relationship of the Co-owner:

_____

If the applicant owns multiple properties, please list them below along with ownership detail.

_____

_____

_____

In the last Five (5) years, has the applicant gifted or transferred money or assets?

NO ☐ YES ☐ ****This question allows us to evaluate for Medicaid eligibility. ****

If Yes, please explain below:

_____

_____

_____

_____

_____

Monthly Income:

Social Security: _____
Pension: _____
Pension: _____
Other Income: _____
TOTAL: _____

Any other income information: _____

_____

Liabilities: Does the patient have a mortgage, money owed, debt? **NO ☐ YES ☐**

_____

_____

_____

CAPITAL ASSETS

Savings Account: _____last month balance
Checking Account: _____last month balance
Other Account: _____last month balance
Other Account: _____last month balance
Other Account: _____last month balance

Last month statement <u>MUST</u> be provided in order to verify the information being reported on this document. All financial statements provided are kept <u>CONFIDENTIAL</u>. The information that is being requested is to help us determine if the applicant will be eligible for Medicaid services.

By affixing my signature to this application, I hereby affirm that I have not transferred any real and/or personal assets or property within the last 60-month period, nor will I

transfer any real and/or personal property held by me, for less than fair market value, for as long as this application is in process.

In the event that any of my assets or property have been transferred or sold within the last 60-months, I have provided a complete disclosure of such transactions below in the space provided or have attached a complete explanation in an addendum.

Disclosure of all transferred assets: _____
_____
_____
_____
_____

I understand that a transfer of assets or property (without compensation at fair market value) will be considered in determining admission eligibility.

If admitted, I will abide by the rules of Greenwood House and apply for any governmental aide programs which may be necessary. I agree to complete any statement requirements required for the admissions process. It is with the understanding that all income, real and/or personal assets belonging to me, the applicant, will be considered available as payment for care and services.

I hereby affirm that the information on this application is true and correct.

_____ _____
Applicant (Responsible Party) Signature Applicant (Responsible Party) Print

_____
Date Signed

Office Use

Reviewed By: _____ Approved: ____ Denied: _____
Denial Reason: _____
Date: _____

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

- Please print and complete all questions.
- This form must be completed for all applicants **PRIOR TO** nursing facility (NF) admission in accordance with Federal PASRR Regulations 42 CFR § 483.106.
- **ALL POSITIVE LEVEL I SCREENS are to be faxed to the appropriate agencies including Office of Community Choice Options (OCCO), Division of Developmental Disabilities (DDD) and/or Division of Mental Health and Addiction Services (DMHAS), as applicable.**
- **ALL 30-DAY EXEMPTED HOSPITAL DISCHARGE SCREENS are to be faxed to OCCO, DDD and/or DMHAS, as applicable**.
- For first time identification of mental Illness (MI) and/or intellectual disability/developmental disability/related condition (ID/DD/RC), the Level I Screener must provide written notice to the applicant and/or their legal representative that MI and/or ID/DD/RC is suspected or known and that a referral is being made to DMHAS and/or DDD for a PASRR Level II Evaluation. The Notice of Referral for a PASRR Level II Evaluation form (LTC-29) can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage at **http://www.state.nj.us/humanservices/doas/home/forms.html.**
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT TO THE NF DURING PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

SECTION I – DEMOGRAPHICS AND CLINICAL ASSESSMENT STATUS

Name of Applicant *(Last Name, First Name)*		Social Security Number
Current Location Address	County of Current Location	Date of Birth

Current Location Setting
☐ Acute Care Hospital ☐ Home/Apartment ☐ Residential Health Care Facility ☐ Group Home/Boarding Home
☐ Psychiatric Hospital/Unit ☐ Assisted Living Residence ☐ Other (Specify): _____

Clinical Assessment/Authorization Status
☐ Current Assessment/Authorization Date: _____
☐ Referred to OCCO for Clinical Assessment (No MCO Enrollment) - Referral Date: _____
☐ Private Pay ☐ Other (Specify): _____

SECTION II – MENTAL ILLNESS SCREEN

1. Does the individual have a diagnosis or evidence of a major mental illness limited to the following disorders: schizophrenia, schizoaffective, mood (bipolar and major depressive type), paranoid or delusional, panic or other severe anxiety disorder; somatoform or paranoid disorder; personality disorder; atypical psychosis or other psychotic disorder (not otherwise specified); or, another mental disorder that may lead to chronic disability? ..... ☐ Yes ☐ No

   Specify Diagnosis(es) based on DSM-5 or current ICD criteria and include any current substance-related disorder diagnosis(es):

   _____

2. Has the individual had a significant impairment in functioning related to a suspected or known diagnosis of mental illness?
   (Record YES if ANY of the three subcategories below are checked) ..... ☐ Yes ☐ No

Check all that apply:

a. ☐ ***Interpersonal functioning***. The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, unstable employment, fear of strangers, avoidance of interpersonal relationships and social isolation.

b. ☐ ***Concentration, persistence, and pace***. The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these task.

c. ☐ ***Adaptation to change***. The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interactions; agitation, exacerbated signs and symptoms associated with the illness or withdrawal from situations, self-injurious, self-mutilation, suicidal, physical violence or threats, appetite disturbance, delusions, hallucinations, serious loss of interest, tearfulness, irritability or requires intervention by mental health or judicial system.

3. Within the last 2 years has the individual (record YES if EITHER/BOTH of the two subcategories below are checked): .... ☐ Yes ☐ No

a. ☐ Experienced one psychiatric treatment episode that was more intensive than routine follow-up care (e.g., had inpatient psychiatric care; was referred to a mental health crisis/screening center; has attended partial care/hospitalization; or has received Program of Assertive Community Treatment (PACT) or Integrated Case Management Services); and/or

b. ☐ Due to mental illness, experienced at least one episode of significant disruption to the normal living situation requiring supportive services to maintain functioning while living in the community, or intervention by housing or law enforcement officials?

   If yes, explain and provide dates:

   _____

   _____

SECTION II - SCREENING OUTCOME for MI Screen Questions 1 through 3 (check one outcome only)

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

☐ **Positive Screen MI**	**If ALL Questions 1 through 3 are answered YES, screen is Positive for MI. Continue to Section III for ID/DD/RC Screen**
☐ **Negative Screen MI**	**If Questions 1 through 3 are answered with any combination of NO, screen is Negative for MI. Continue to Section III for ID/DD/RC Screen**

SECTION III – INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY/RELATED CONDITIONS SCREEN

4. **Intellectual disability (ID) is a significantly decreased level of intellectual functioning measured by a standardized, reliable test of intellectual functioning and encompasses a wide range of conditions and levels of impairment with concurrent impairments in adaptive functioning. The ID must have manifested prior to the age of 18.**
   Does the individual have a current diagnosis or a history of intellectual disability (mild, moderate, severe or profound) and/or is there any presenting evidence (cognitive or behavior characteristics) that may indicate the person has an intellectual disability with date of onset prior to age 18? ……..…….....☐ Yes ☐ No
   If yes, explain: _____
   _____

5. **Related conditions (RCs) are severe, chronic developmental disabilities, but not forms of intellectual disabilities, that produce similar functional impairments and require similar treatment or services. RCs must have manifested prior to the age of 22.**
   Does the individual have a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability with date of onset prior to age 22 that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction, learning, understanding/use of language, capacity for independent living (e.g., autism, seizure disorder, cerebral palsy, Spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf or closed head injury)? ……..…….....☐ Yes ☐ No
   If yes, explain: _____
   _____

6. Does the individual currently receive services or previously received services paid through the Division of Developmental Disabilities (DDD) (e.g., day habilitation, group home, case management, Community Care Waiver, Real Life Choices, Family Support of Self Determination), or other agency? ……..…….....☐ Yes ☐ No

7. Was a referral made from an agency that serves individuals with ID/DD/RC in the past? ……..…….....☐ Yes ☐ No
   If yes, referred from what agency? _____

SECTION III - SCREENING OUTCOME for ID/DD/RC Screen Questions 4 through 7 (check one outcome only)

☐ **Positive Screen ID/DD/RC**	**If ANY responses to Questions 4 through 7 are YES, screen is Positive for ID/DD/RC**
☐ **Negative Screen ID/DD/RC**	**If ALL responses to Questions 4 through 7 are No, screen is Negative for ID/DD/RC**

(continue to next page)

SECTION IV – PASRR LEVEL I SCREENING OUTCOME AND REFERRAL, IF INDICATED

Name of Applicant *(Last Name, First Name)*	Social Security Number

STEP 1: Determine Screening Outcomes for Sections II and III (check ONE response for EACH Section):

☐ Positive ☐ Negative	**Section II – MI Screen**
☐ Positive ☐ Negative	**Section III – ID/DD/RC Screen**

STEP 2: Determine Final Level I Screening Outcome (check ONE final screening outcome only):

☐	**Negative Screen**	**If Step 1 Section II Negative Section III Negative**	**Admit to NF**
☐	**Positive Screen MI Only**	**If Step 1 Section II Positive Section III Negative**	**Refer to DMHAS**
☐	**Positive Screen ID/DD/RC only**	**If Step 1 Section II Negative Section III Positive**	**Refer to DDD**
☐	**Positive Screen MI and ID/DD/RC**	**If Step 1 Section II Positive Section III Positive**	**Refer to both DMHAS and DDD**

ALL POSITIVE PASRR LEVEL I SCREENS ARE TO BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. NF ADMISSION IS CONTINGENT UPON RECEIPT OF LEVEL II EVALUATION AND DETERMINATION.

For first time identification of MI and/or /ID/DD/RC, the Level I Screener must provide written notice to the NF applicant or legal representative that MI and/or ID/DD/RC is suspected or known, and that a referral is being made to DMHAS and/or DDD for Level II Evaluation. The Notice of Referral for a Level II Evaluation form (LTC-29) can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage at: **https://www.state.nj.us/humanservices/doas/home/forms.html**

Remember, when referring for a Level II PASRR Evaluation and Determination, Section IX must be completed to ensure notification of the PASRR Level II Determination.

PASRR LEVEL II DETERMINATION REQUESTS, IF INDICATED

If the Level I Screening outcome is positive for MI and/or ID/DD/RC, the Level I Screener can request, as applicable, one of the following PASRR Level II determination requests:

- **If the Level I Screen is positive for MI only, a MI Primary Dementia Exclusion can be requested by completing Section V.**
- **If the Level I Screen is positive for MI and/or ID/DD/RC, a Categorical Level II Determination can be requested by completing Section VI.**
- **If the Level I Screen is positive for MI and or ID/DD/RC, a 30-Day Exempted Hospital Discharge can be requested by completing Section VII.**

(continue to next page)

SECTION V – MENTAL ILLNESS PRIMARY DEMENTIA EXCLUSION for Positive Level I Screens for Mental Illness

Name of Applicant *(Last Name, First Name)*	Social Security Number

The Mental Illness Primary Dementia Exclusion applies to individuals who have a confirmed diagnosis of dementia and that the dementia diagnosis is documented as primary or more progressed than a co-occurring MI.

☐ **Primary Dementia Exclusion requested (check if applicable)**

For an individual with a Positive Level I Screen for MI with a diagnosis of Dementia and the Dementia is primary or more progressed than the co-occurring MI, a referral to the DMHAS for the PASRR Level II evaluation and determination is required prior to NF admission:

Fax the completed Positive Level I Screen, the Notice of Referral for PASRR Level II Evaluation (LTC-29), and the completed PASRR Level II Psychiatric Evaluation form, which can be downloaded from the New Jersey DHS, DMHAS at **https://nj.gov/humanservices/dmhas/forms/**, to the **DMHAS to 609-341-2307 and to the OCCO Regional Office (see Section XI).** The LTC-29 can be downloaded from the New Jersey DHS, Division of Aging Services forms webpage **https://www.state.nj.us/humanservices/doas/home/forms.html.**

SECTION VI – CATEGORICAL DETERMINATION FOR LEVEL I POSITIVE SCREENS

Federal PASRR Regulation 42 CFR § 483.140 permits states to make a categorical determination and omit the full Level II Evaluation in certain circumstances that are time-limited or where the need for NF is clear. Categorical determinations are *not* "exemptions".

PASRR Level I Screeners can request a categorical determination for a positive Level I Screen based on any one of four categories. Complete this section if you are requesting a categorical determination for an individual with a positive Level I Screen for MI and/or ID/DD/RC, based on any one of the following:

(Check the box for the appropriate condition or circumstance)

- ☐ **Terminal Illness -** Terminally ill with a medical prognosis of life expectancy six months or less; not a danger to self or others.
- ☐ **Severe Physical Illness -** A medical condition of such severity that prohibits participation in or benefitting from specialized services.
- ☐ **Respite Care –** To provide short term respite to the caregiver, admission from a non–institutional setting not to exceed 30 days.
- ☐ **Protective Service (APS) -** Referred by APS when NF admission is necessary, not to exceed 7 days while alternative arrangements are made.

A referral to DMHAS for a categorical determination requires completion of the DMHAS Categorical Determination form, which can be found at the New Jersey DHS, DMHAS website: **https://nj.gov/humanservices/dmhas/forms/.** This completed Categorical Determination form, along with the completed positive Level I Screen, and the Notice of Referral for Level II PASRR Evaluation (LTC-29), must be faxed to **DMHAS at 609-341-2307 (see Section XI).**

A referral to DDD for a categorical determination requires the completed positive Level I Screen and the Notice of Referral for Level II PASRR Evaluation (LTC-29) be faxed to the **DDD Central Fax Number at 609-341-2349 (see Section XI).**

The Notice of Referral for Level II PASRR Evaluation (LTC-29) can be downloaded from the New Jersey Department DHS, Division of Aging Services forms webpage at: **https://www.state.nj.us/humanservices/doas/home/forms.html.**

All Positive Level I Screens are to be faxed to OCCO **(see Section XI)**.

SECTION VII – 30-DAY EXEMPTED HOSPITAL DISCHARGE FOR LEVEL I POSITIVE SCREENS

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

☐ 30-Day Exempted Hospital Discharge - Applies only to INITIAL NF admission NOT resident review, NF readmission or inter-facility transfer. Complete this section for all Positive Screens meeting the following criteria:

EXEMPTED HOSPITAL DISCHARGE – An individual may be admitted to a skilled NF directly from the hospital after receiving inpatient care (non-psychiatric) at the hospital if:

- The individual requires skilled nursing facility services for the condition for which he/she received care in the hospital **AND**
- The attending hospital physician certifies before the NF admission that the individual is likely to require less than 30 days skilled nursing facility care.

Name of Physician (Print):	Signature of Physician:	Date:

NURSING FACILITIES PLEASE NOTE THE FOLLOWING IMPORTANT INFORMATION ABOUT 30-DAY EXEMPTED HOSPITAL DISCHARGES:

- **If the individual requires care beyond the initial 30-day period, the NF must notify DMHAS and/or DDD, as applicable, prior to the individual's 30th day in the NF, and must provide a written explanation of the reason for the continued stay including the anticipated length of stay.**
- **Federal regulations require that the PASRR Level II Evaluation and Determination be completed prior to the individual's 40th day in the NF.**
  - **Admission under the above exemption does not relieve the NF of its responsibility to ensure that specialized services are provided to an individual who has MI or ID/DD/RC needs and who would benefit from those services.**
- **FAILURE TO ABIDE BY PASRR RULES WILL RESULT IN FORFEITURE OF MEDICAID REIMBURSEMENT FOR NF SERVICES DURING THE PERIOD OF NON-COMPLIANCE IN ACCORDANCE WITH FEDERAL PASRR REGULATIONS 42 CFR 483.122.**

SECTION VIII – PASRR LEVEL I SCREENING OUTCOME AND CERTIFICATION OF SCREENING PROFESSIONAL COMPLETING LEVEL I FORM

Outcome of Level I Screen
(check ONE Negative or Positive screening outcome)

☐ **Negative Screen:** Admit to NF

☐ **Positive Screen:** Referring for Level II Evaluation and Determination prior to NF admission (check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

☐ **Positive Screen - Requesting Primary Dementia Exclusion Determination:** Referring for Level II Evaluation and Determination prior to NF admission.
☐ MI

☐ **Positive Screen - Requesting Categorical Determination:** Referring for a Categorical Level II Evaluation and Determination prior to NF Admission (check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

☐ **Positive Screen - 30-Day Exempted Hospital Discharge**
(check one of the following)
☐ MI ☐ ID/DD/RC ☐ MI & ID/DD/RC

Attending hospital physician must certify Section VII. Fax completed form to OCCO, DMHAS and/or DDD, as applicable, and then the individual can be discharged to the nursing facility.

Name of Provider/Agency/Program:
_____

Title of Screening Professional:
_____

Screening Professional Phone Number:
_____

Screening Professional Fax Number:
_____

Name of Screening Professional Completing Form (print):
_____

Signature of Screening Professional Completing Form:
_____

Date:
_____

REMEMBER: ALL POSITIVE PASRR LEVEL I SCREENS MUST BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. THANK YOU.

PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)
LEVEL I SCREENING TOOL (continued)

Name of Applicant *(Last Name, First Name)*	Social Security Number

SECTION IX – REQUIRED CONTACT INFORMATION FOR ALL POSTIVE LEVEL I SCREENS

1. **Name of Referring Entity** (Screening professional's affiliation such as agency, hospital, NF, other healthcare provider, MCO, etc.)**:** _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
2. **Consumer's Residing Address/Street** (Consumer's primary residence)**:** _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
3. **Name of Legal Representative** (Last Name, First Name)**:** _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
4. **Name of Family Member** (if available and consumer or legal representative agrees to family contact/notification)**:** _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____
5. Name of Attending Physician: _____ Address / Street: _____ Town / Zip Code: _____	**Phone Number:** _____ **Fax Number:** _____

SECTION X – CONTACT INFORMATION

Division Of Mental Health and Addiction Services (DMHAS)	**Division of Aging Services (DoAS) Office of Community Choice Options (OCCO) Regional Offices**	**Division of Developmental Disabilities (DDD)**
Statewide PASRR Coordinator for Mental Health: **Phone:** 609-438-4152 or 609-438-4146; **Fax: 609-341-2307**	**NORTHERN REGIONAL OFFICE OF COMMUNITY CHOICE OPTIONS (NRO):** Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union and Warren Counties **Phone:** 732-777-4650; **Fax: 732-777-4681** **SOUTHERN REGIONAL OFFICE OF COMMUNITY CHOICE OPTIONS (SRO):** Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer, Monmouth, Ocean and Salem Counties **Phone:** 609-704-6050; **Fax: 609-704-6055**	**DDD Central Fax Number:** **609-341-2349** **DDD Regional Offices - Phone Numbers** **NEWARK**: Bergen, Essex and Hudson **Phone:** 973-693-5080 **PLAINFIELD:** Hunterdon, Somerset and Union **Phone:** 908-226-7800 **FLANDERS**: Morris, Passaic, Sussex and Warren **Phone:** 973-927-2600 **FREEHOLD:** Middlesex, Monmouth and Ocean **Phone:** 732-863-4500 **TRENTON**: Burlington and Mercer **Phone:** 609-584-1340 **MAYS LANDING**: Atlantic, Cape May and Cumberland **Phone:** 609-476-5200 **VOORHEES**: Camden, Gloucester and Salem **Phone:** 856-770-5900

Department of Human Services
Division of Aging Services
Office of Community Choice Options

Instructions for the Completion of the Pre-Admission Screening and Resident Review (PASRR) Level l Screen

Section I – Demographics and Clinical Assessment Status

- **Name of Applicant:** Provide legal name, including last name and first name.
- **Social Security Number:** Individuals full social security number.
- **Current Location Address:** Where the individual is when completing the PASRR Level I Screen.
- **County of Current Location:** County where individual is located when filling out the PASRR Level I Screen.
- **Date of Birth:** Self-explanatory.
- **Current Location Setting:** Where the individual is when the PASRR Level I Screen is filled out (hospital, community, home etc.). Check one.
- **Clinical Assessment/Authorization Status:** Check applicable clinical assessment status.

Section II - Mental Illness Screen

1. **Does the individual have a diagnosis or evidence of a major mental illness?**
   Check box for "Yes" or "No". If yes, specify diagnosis and include any current substance-related disorder diagnosis.
2. **Has the individual had a significant impairment in functioning related to a suspected or known diagnosis of mental illness?** (Review subcategories 2a. – 2c., check those applicable)
   Check box for "Yes" if any of the three subcategories are checked.
3. **Within the last two years has the individual…** (Review subcategories 3a. and 3b., check those applicable)
   Check box for "Yes" if either/both of the two subcategories are checked. If yes is checked, explain and provide dates.

Section II - Screening Outcome for MI Screen Questions 1 through 3

- Complete this section referring to Section II questions 1 through 3. Check one outcome only.
  - Check box for a **Positive Screen MI** if <u>all</u> questions 1 through 3 are answered "Yes".
  - Check box for a **Negative Screen MI** with <u>any combination of "NO"</u> for questions 1 through 3.

Section III - Intellectual Disability/Developmental Disability/Related Conditions Screen (ID/DD/RC)

4. **The definition of an intellectual disability (ID) is a significantly decreased level of intellectual functioning measured by a standardized, reliable test of intellectual functioning and encompasses a wide range of conditions and levels of impairment with concurrent impairments in adaptive functioning. The ID must have manifested prior to the age of 18.**
   Check box for "Yes" or "No" to indicate if the individual has a current diagnosis or a history of intellectual disability with an onset prior to age 18. If "Yes", provide explanation.
5. **The definition of a related condition (RC) is severe, chronic developmental disability, but not forms of intellectual disabilities, that produce similar functional impairments and require similar treatment or services. RCs must have manifested prior to the age of 22.**
   Check box for "Yes" or "No" to indicate if the individual has a current diagnosis, history or evidence of a related condition that may include a severe, chronic disability with <u>date of onset prior to age 22</u> that is attributable to a condition other than mental illness that results in impairment of general intellectual functioning or adaptive behavior, mobility, self-care, self-direction, learning, understanding/use of language, capacity for independent

living (e.g., autism, seizure disorder, cerebral palsy, spina bifida, fetal alcohol syndrome, muscular dystrophy, deaf or closed head injury). If "Yes", provide explanation.

6. **Does the individual receive services or previously received services paid through the Division of Developmental Disabilities (DDD)?**
   Check box for "Yes" or "No" to indicate if the individual is currently or known to have received services through DDD.
7. **The question is seeking to know if a referral was made from an agency that serves individuals with ID/DD/RC.**
   Check box for "Yes" or "No", and if "Yes", identify from what agency the referral was made.

Section III - Screening Outcome for ID/DD/RC Screen Questions 4 through 7

- **Complete this section referring to Section III questions 4 through 7.** Check one outcome only.
  - Check the box for a **Positive Screen ID/DD/RC** if ANY responses to questions 4 through 7 are "Yes".
  - Check the box for a **Negative Screen ID/DD/RC** if ALL responses to questions 4 through 7 are "No".

Section IV - PASRR Level I Screening Outcomes and Referral, if Indicated

- **Step 1**: **Determine Screening Outcome for Sections II and III.** Check one box for each section. Indicate "Positive" or "Negative" Screening Outcome for MI and ID/DD/RC as applicable.
- **Step 2**: **Determine Final Level 1 Screening Outcome.** Check only one box to identify screening outcome for this step and follow the directions if the screen is positive, to forward the referral to the applicable agency(ies) - DMHAS and/or DDD.

ALL POSITIVE PASRR LEVEL I SCREENS ARE TO BE FAXED TO OCCO, DMHAS AND/OR DDD, AS APPLICABLE. NF ADMISSION IS CONTINGENT UPON RECEIPT OF LEVEL II DETERMINATION OUTCOME.

Section V- Mental Illness Primary Dementia Exclusion for Positive Level l Screens for Mental Illness

The Mental Illness Primary Dementia Exclusion applies to individuals who have a confirmed diagnosis of dementia and that the dementia diagnosis is documented as primary or more progressed than a co-occurring mental illness.

- Check box for "**Primary Dementia Exclusion requested**", if applicable.
  - If checked, a referral to the DMHAS for the PASRR Level II evaluation and determination is required prior to NF admission.
  - Fax the completed Positive Level I Screen, the Notice of Referral for PASRR Level II Evaluation (LTC-29), and the completed PASRR Level II Psychiatric Evaluation form to the DMHAS as per instructions on form. The DMHAS will issue the PASRR Level II determination.

Section VI - Categorical Determinations for Level I Positive Screens

A Categorical Determination omits the need for a full Level II Evaluation in certain circumstances that are time-limited or where the need for NF is clear.

- Check box for the requested type of "**Categorical Determination**", if applicable.
  - If requesting a categorical determination for the Positive PASRR Level I Screen, you must check the box beside the appropriate condition/circumstance, and contact DDD and/or DMHAS as applicable.
  - DMHAS has a categorical determination form that will need to be completed for a categorical determination. A link to this form is in this section on the PASRR Level I Screen.

Section VII - 30-Day Exempted Hospital Discharge for Level I Positive Screens

Hospital Exemption applies only to **initial NF admission**; it does not apply to resident review for change in condition, NF readmission or inter-facility transfer.

- The individual must meet the following criteria to be considered for a PASRR Level I 30 Day Exempted Hospital Discharge:
  - The individual has received inpatient non psychiatric care at an acute care hospital; **and**
  - The individual requires skilled nursing services for the condition which he or she received care in the hospital; **and**
  - The hospital physician certifies before the NF admission that the individual is likely to require less than 30 days skilled nursing facility care.
- This section **must be signed by the hospital physician** that is certifying the 30-DayExempted Hospital Discharge, or it will not be processed.
- The PASRR Level I form is then faxed to DMHAS and/or DDD **and** OCCO prior to the individual being discharged to the NF.

Section VIII - PASRR Level I Screening Outcome and Certification of Screening Professional Completing the Level I Form

- **Outcome of Level I Screen:** Check box applicable to outcome.
- **Name of Provider/Agency/Program:** Fill in provider name, agency and/or program where the PASRR Level I Screen is being completed.
- **Title of Screening Professional:** Print title of Screener.
- **Screening Professional Phone Number:** Phone number where the Screener can be reached if additional information is needed.
- **Screening Professional Fax Number:** Where the reviewed PASRR is to be faxed, when applicable.
- **Name of Screening Professional:** Print name of Screener completing the form.
- **Signature of Screening Professional:** Signature of Screener completing the form.
- **Date:** Date form is completed and faxed to the OCCO Regional Office.

Important:

All Positive PASRR Level I Screens, including those certified by the physician as a 30-Day Exempted Hospital Discharge are to be faxed to OCCO, DMHAS and/or DDD as applicable, prior to the individual being discharged to the NF.

Section IX- Required Contact information for All Positive Level I Screens

This section must be completed for all Positive Level I Screens. If this section is left blank, the Level I Screen will not be processed. This section allows for the determination of the Level II Authority to be sent to the referring entity, consumer, Legal Representative, if applicable, and Family member if permission is received from the individual, and the attending physician.

Section X - Contact Information

This section contains the phone numbers for the local DMHAS, OCCO, DDD agencies/legal authorities. The fax numbers are also included to indicate where the completed Positive PASRR Level I Screens, as well as referrals for the Level II Evaluation and Determinations are to be sent.